Conducting Chronic Quality Improvement, Years 1-3

Project Goal: Use the Plan Do Study Act (PDSA) quality improvement process to improve a blood pressure-related health outcome for clinic patients.

Clinic Characteristics

<table>
<thead>
<tr>
<th>Clinic type</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic type</td>
<td>3 - Primary care</td>
<td>2 - Rural Health Clinic</td>
<td>1 - Tribal Health</td>
</tr>
<tr>
<td>Location</td>
<td>3 - Rural</td>
<td>2 - Urban</td>
<td>1 - Urban</td>
</tr>
</tbody>
</table>

Type of QI Strategies

- Develop standardized protocols/practices
  - Hypertension protocol
  - Blood pressure (BP) re-checks
- Implement self-measured blood pressure monitoring (SMBP)
- Implement Care Management
- Use Electronic Health Record (EHR) data and data analytics
  - Patient identification
  - Add BP control to dashboard
  - Clinical decision support (e.g., reminder system)
- Enhance standard workflow
  - Schedule patient follow-up visits
  - Referrals (e.g., pharmacist, care management, etc.)
- Offer staff training/education
  - Accurate BP measurement
- Offer patient training/education
  - Life-style
  - Accurate BP measurement

Facilitators

- Physician Champion
- Dedicated staff
- Provider/staff buy-in and engagement
- Standardized protocols and training
- Leadership support
- Hypertension as a priority
- Use of data and data analytics (e.g., Dashboard, code to bill BP education and SMBP)
- Communication
- Being proactive

COVID-19

- Provider buy-in
- Consensus of BP targets and protocols
- Competing priorities
- Providers unfamiliar with all programs (e.g., SMBP, Chronic Care Model, etc.)
- Use of data and data analytics
- Poor attendance at patient follow-up appointments
- Inconsistent scheduling of follow-up appointments
- Medication changes not communicated on discharge

Barriers

- Hypertension as a priority
- Use of data and data analytics
- Poor attendance at patient follow-up appointments
- Inconsistent scheduling of follow-up appointments
- Medication changes not communicated on discharge

Sustainability

- Make SMBP a standard of care
- Implement population health model to identify care gaps
- Keep hypertension a priority
- Use of data and data analytics
- Use reimbursable services

Results - 15 Participating Clinics

<table>
<thead>
<tr>
<th>Measure</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measured BP control (e.g., CMS 165)</td>
<td>14/15</td>
<td>10 improved pre to post</td>
<td></td>
</tr>
<tr>
<td>Implemented care/case management</td>
<td>n/a</td>
<td>232 participating patients</td>
<td></td>
</tr>
<tr>
<td>Implemented hypertension protocol</td>
<td>n/a</td>
<td>42 employees trained</td>
<td></td>
</tr>
<tr>
<td>Hypertension program</td>
<td>n/a</td>
<td>72 patients</td>
<td></td>
</tr>
<tr>
<td>Measured hypertension (e.g., accurate BP measurement or BP re-checks)</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Implement care plans</td>
<td>n/a</td>
<td>306 employees trained</td>
<td></td>
</tr>
<tr>
<td>Provided referrals (e.g., providers or care management)</td>
<td>n/a</td>
<td>21 patient referrals</td>
<td></td>
</tr>
<tr>
<td>Improved follow-up for elevated BP</td>
<td>n/a</td>
<td>147 patients</td>
<td></td>
</tr>
<tr>
<td>implemented BP - check</td>
<td>n/a</td>
<td>60 patients</td>
<td></td>
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</tbody>
</table>

*14 of 15 clinics were able to obtain pre/post data.